



SENTARA

Medical Group

Patient Information

Date

PATIENT INFORMATION

Patient Name (Last) (First) (MI) Social Security Number
 Mr. Mrs. Ms. Dr.

Birth Date Sex Male Female Marital Status Married Single Divorced Separated Widowed

Home Address: Street Apt. No. City

State Zip Code Home Phone () Work Phone () Alternate Number () Cell Phone ()

E-Mail Address Would You Like to Receive Information by E-Mail? Yes No Employer Name and Address

Are you currently taking 5 or more medications?
 If yes, please request and complete a Patient Medication card. Yes No

How did you hear about SMG? Newspaper Friend Radio TV Direct Mail Physician Referral Other

Whom should we thank for your referral? _____

GUARANTOR INFORMATION

(PERSON FINANCIALLY RESPONSIBLE FOR BILLS AFTER INSURANCE COMPANY PAYMENT)

Please Check Box to Indicate if Information is Same as Patient Same as Patient

Guarantor Name Social Security Number

Patient's Relationship to Guarantor: Self Spouse Dependent Child Student Other

Home Address: Street Apt. No. City

State Zip Code Home Phone () Work Phone ()

Employer Name and Address

INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE COMPANY

Insurance ID No. (Member/Certificate) Plan Name Plan No. Group No.

Subscriber Name (The primary name in which the insurance policy is held) Effective Date

Social Security Number Subscriber D.O.B. Primary Physician

Patient's Relationship to Subscriber: Self Spouse Dependent Child Student Other

SECONDARY MEDICAL INSURANCE COMPANY

Insurance ID No. (Member/Certificate) Plan Name Plan No. Group No.

Subscriber Name Effective Date

Social Security Number Subscriber D.O.B.

Patient's Relationship to Subscriber: Self Spouse Dependent Child Student Other

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name Phone Number